

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 18 November 2004

In the Matter of:
DAVID D. RICHMOND
Claimant

Case No.: 2003 BLA 5974

v.

P G & H INC./
WEST VIRGINIA CWP FUND
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS

Party in Interest

Appearances: Mr. Joseph Wolfe, Attorney
For the Claimant

Mr. Robert Weinberger, Attorney
For the Employer/Insurer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – DENIAL OF BENEFITS

This matter involves a claim filed by Mr. David D. Richmond for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim (DX 1)¹

Mr. Richmond filed his first application for black lung disability benefits on February 11, 1998. On June 12, 1998, the U.S. Department of Labor (“DOL”) denied his claim for failure to establish the presence of pneumoconiosis and total disability. In response, Mr. Richmond submitted his medical records. On January 29, 1999, after consideration of the additional evidence, the District Director again denied his claim. Mr. Richmond did not appeal the decision.

Second, and Present Claim

On May 13, 2001, Mr. Richmond filed his second claim for black lung disability benefits (DX 3). On May 14, 2002, the District Director initially determined that Mr. Richmond would be entitled to benefits (DX 26). However, on January 31, 2003, after consideration of additional medical information, the District Director denied Mr. Richmond’s claim for failure to demonstrate the presence of pneumoconiosis. On February 12, 2003, through counsel, Mr. Richmond appealed the adverse decision (DX 30). As a result, the case was forwarded to the Office of Administrative Law Judges (“OALJ”) on May 22, 2003 (DX 34). Pursuant to a Notice of Hearing, dated August 20, 2003, I set a hearing date of December 9, 2003 for this case in Beckley, West Virginia. On November 14, 2003, I received a joint request for a decision on the record and cancelled the scheduled hearing.

Evidentiary Discussion

When forwarded to OALJ, Mr. Richmond’s case contained DX 1 to DX 35. After the hearing cancellation, Claimant’s counsel sent me two interpretations by Dr. Ahmed and Dr. Aycoth of a chest x-ray, dated September 11, 2003. Because 20 C.F.R. § 725.414 (a) (2) (i) permits a claimant to submit two chest x-ray interpretations to support his case-in-chief, and since Employer’s counsel did not object to the additional evidence, I now admit CX 1 and CX 2.

My decision in this case will be based on all the evidence in the record: DX 1 to DX 35, CX 1, and CX 2

ISSUES

1. Whether Mr. Richmond in filing a subsequent claim on May 13, 2001 has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the denial of his prior claim was based in January 1999.

¹The following notations appear in this decision to identify exhibits: DX – Director exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

2. If Mr. Richmond establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Born on June 17, 1947, Mr. Richmond married Mrs. Connie J. Richmond on October 22, 1966. He started mining coal in November 1968 and worked through August 1986, with occasional breaks in his employment. Both his recollection and the Social Security Administration earnings record establish at least 15 and a half years of underground coal mine employment. During his mining career, he worked as a faceman, jacksitter, machine operator and foreman. At the time he stopped mining coal in 1986, he was a foreman and clean-up person. In addition to ensuring the safety of the mine, Mr. Richmond also delivered mining supplies and shoveled loose coal. In accomplishing these tasks, he had to lift up to 50 pounds on numerous occasions each day. After he stopped work as a coal miner, Mr. Richmond became a mine safety inspector for the U.S. Department of Labor and continued that employment through 1999. Mr. Richmond smoked cigarettes from when he was 20 years old until he was about 50 years old, at the rate of one pack a day (DX 1, DX 4, DX 7, and DX 9).

Issue #1 – Change in Applicable Condition of Entitlement

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied (“applicable condition of entitlement”) has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner’s physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung

disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.² Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.³ Third, the miner has to demonstrate he is totally disabled.⁴ And fourth, the miner must prove the total disability is due to coal workers' pneumoconiosis.⁵

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Richmond's case, his prior claim was finally denied in January 1999 for failure to prove the presence of pneumoconiosis and total disability. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since January 1999 to determine whether Mr. Richmond can now prove total disability or the presence of pneumoconiosis.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir.*, *OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove

²20 C.F.R. § 718.202.

³20 C.F.R. § 718.203 (a).

⁴20 C.F.R. § 718.204 (b).

⁵*Id.*

that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Richmond has not presented evidence of cor pulmonale with right-sided congestive heart failure and the record contains no evidence of complicated pneumoconiosis.⁶ As a result, Mr. Richmond must demonstrate total respiratory, or pulmonary, disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV ¹ pre ⁷ post ⁸	FVC pre post	MVV pre post	% FEV ¹ / FVC pre post	Qualified ⁹ pre post	Comments
DX 13	Oct. 24, 2001 Dr. Rasmussen	54 66"	1.73 1.95	3.86 3.94	53 68	45% 49%	Yes ¹⁰ Yes	Moderate, slightly reversible obstruction ¹¹
DX 19	June 19, 2002 Dr. Zaldivar	55 66"	1.55 1.61	3.81 3.91	55 70	41% 41%	Yes ¹² Yes	Moderate obstruction

Under the provisions of 20 C.F.R. § 718.204 (c) (1), if the preponderance of the pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary test evidence shall establish a miner's total disability. To apply this regulatory section requires a five step process. First, an administrative law judge must determine whether the tests conform to the pulmonary function test procedural requirements in 20 C.F.R. § 718.103. Second, the results are compared to the qualifying values for the various tests listed in Appendix B to determine whether the test qualifies. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test

⁶An October 1997 CT scan identified a large nodule, 2 by 1.5 centimeters in Mr. Richmond's right upper lung. A subsequent lobectomy and biopsy affirmatively established that the nodule was lung cancer. As a result, I have not treated the presence of the nodule as evidence of complicated pneumoconiosis. See 20 C.F.R. § 718.304 and *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000)

⁷Test result before administration of a bronchodilator.

⁸Test result following administration of a bronchodilator.

⁹Under 20 C.F.R. § 718.204 (b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV¹ must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV¹/FVC has to be equal to or less than 55%.

¹⁰The qualifying FEV¹ number is 1.81 for age 54 and 66"; the corresponding qualifying FVC and MVV values are 2.30 and 73, respectively.

¹¹Valid pulmonary function test per Dr. Michos (DX 14).

¹²The qualifying FEV¹ number is 1.80 for age 55 and 66"; the corresponding qualifying FVC and MVV values are 2.28 and 72, respectively.

results. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains “contrary probative evidence.” If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is made to see if it outweighs the pulmonary function tests that support a finding of total respiratory disability. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987).

With these principles in mind, I first note the two pulmonary function studies performed since the denial of Mr. Richmond’s last claim appear to conform to regulatory standards and no physician has challenged their validity. Next, both tests produced results that were qualifying under the regulation to establish total disability. In terms of contrary evidence, none really appears in the newly developed record. Instead, Dr. Rasmussen (DX 11) and Dr. Zaldivar (DX 19) agree that Mr. Richmond is unable to return to coal mining due to a pulmonary impairment. As a result, I find that Mr. Richmond has established total disability under 20 C.F.R. §§ 718.204 (b) (1) and (2) (i).

Summary

Mr. Richmond has proven through two recent pulmonary function tests that he is totally disabled. Having established that one of the conditions of entitlement that he previously failed to prove has changed and is now present, Mr. Richmond has satisfied the provisions of 20 C.F.R. §725.309 (d). As a result, I must now examine the entire medical record to determine whether Mr. Richmond is entitled to black lung disability benefits.

Issue #3 – Entitlement to Benefits

As previously summarized, to receive benefits under the Act, a claimant must prove by preponderance of the evidence: 1) the presence of pneumoconiosis; 2) pneumoconiosis due to coal mine employment; 3) total disability; and, 4) total disability due to coal workers’ pneumoconiosis.

Pneumoconiosis

“Pneumoconiosis” is defined as a chronic dust disease arising out of coal mine employment.¹³ The regulatory definitions include both a) clinical, or medical pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis; and, b) legal pneumoconiosis, defined as “any chronic lung disease arising out of coal mine employment.”¹⁴ The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” 20 C.F.R. § 718.201

¹³20 C.F.R. § 718.201 (a).

¹⁴20 C.F.R. § 718.201 (a)(1) and (2).

(b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

Under the regulation, 20 C.F.R. § 718.201 (a) (1), clinical pneumoconiosis has two components: a) “permanent deposition of substantial amount of particulate matter in the lungs,” and, b) “fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment.” This regulatory definition also specifically includes “anthracosis.”

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),¹⁵ and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Richmond has complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. As a result, Mr. Richmond will have to rely on biopsy, chest x-rays or medical opinion to establish the presence of pneumoconiosis. In addition, since Mr. Richmond last mined coal in West Virginia, his case comes within the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit. In that circuit, according to the court’s guidance in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must consider all the evidence (biopsy, chest x-ray, and medical opinion) together to determine whether Mr. Richmond can establish the presence of pneumoconiosis.

Biopsy (DX 1)

On January 7, 1998, as part of a diagnostic fine needle biopsy and subsequent right upper lobectomy, Dr. Eric C. Wilson, a board certified pathologist,¹⁶ conducted both microscopic evaluation of both the biopsy specimen and sections of the right upper lobe of Mr. Richmond’s lung and the mediastinal nodes.

Through the microscope, Dr. Wilson noted the presence of malignant squamous cell carcinoma in the biopsy from the right upper lung. In addition to the tumor, Dr. Wilson found “background fibrosis and soot dust deposition within the lung parenchyma.”

Upon completion of the right upper lobectomy, Dr. Wilson also examined multiple sections of the lung under the microscope. In one section, Dr. Wilson reported, “only a few clusters of dust laden pigmented macrophages.”¹⁷ In another section, he noted, “relative

¹⁵If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

¹⁶I take judicial notice of Dr. Wilson’s board certification and have attached the certification documentation.

¹⁷A macrophage is a rounded, granular, mononuclear phagocyte (cell) within the alveoli of the lungs that ingests inhaled particulate matter. DORLAND’S ILLUSTRATED MEDICAL DICTIONARY 977 and 1270 (28th ed. 1994).

abundant histiocytes¹⁸ containing dusty brown black pigment. . .and pigment aggregates of dust-like brown black pigment around small vascular structures throughout the lung parenchyma.” In another “random section submitted as B-5,” the physician discovered “similar perivascular soot dust accumulation within macrophages and free within the slightly increased fibrous tissue around the vessels.” However, in the same section, Dr. Wilson did not see any “obvious coal macules¹⁹.”

Based on his observations, Dr. Wilson diagnosed “anthracosis, right upper lobe of lung and perihilar and parenchymal lymph nodes.” Through his observations and diagnosis, Dr. Wilson has established the presence of pneumoconiosis under the regulations.²⁰ In the biopsy sample, the pathologist saw both dust deposition and a background of fibrotic tissue. In other lung sections, in addition to the presence of dust soot, he observed abundant lung cells that had ingested brown-black pigment. In other parts of the lung, Dr. Wilson noted a few clusters of the pigment-laden pulmonary cells. Although he did not identify coal macules in one lung section, Dr. Wilson’s other findings support his diagnosis of anthracosis, which under the regulation falls within the definition of pneumoconiosis.

Compton Analysis

Even though Mr. Richmond’s lung biopsy samples show the presence of pneumoconiosis, under the *Compton* mandate, I must nevertheless consider the biopsy findings in conjunction with all the chest x-ray and medical opinion evidence in the record

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
Oct. 17, 1997	DX 1	Dr. Tzouanakis	Ill-defined, 2 x 2 centimeter nodule right upper lung
Nov. 11, 1997	DX 1	Dr. Riley	Ill-defined infiltrate right upper lobe; left lung clear
Jan. 7, 1998	DX 1	Dr. Cole, BCR, B ²¹	Negative for pneumoconiosis; post-op right pneumothorax
Jan. 8, 1998	DX 1	Dr. Cole, BCR, B	Negative for pneumoconiosis; probable carcinoma right lung
(same)	DX 1	Dr. Peat	Small bilateral effusion

¹⁸“Macrophage.” DORLAND’S ILLUSTRATED MEDICAL DICTIONARY 769 (28th ed. 1994).

¹⁹“Stain, spot, or thickening.” DORLAND’S ILLUSTRATED MEDICAL DICTIONARY 978 (28th ed. 1994).

²⁰See also *Hapney v. Peabody Coal Co.*, 22 B.L.R. 1-106 (2001) (en banc) (a diagnosis of anthracosis on biopsy falls within the definition of pneumoconiosis under 20 C.F.R. § 718.201 (a) (1)).

²¹The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. See also 20 C.F.R. § 718.202 (a) (1) (ii).

Jan. 12, 1998	DX 1	Dr. Cole, BCR, B	Negative for pneumoconiosis; possible carcinoma recurrence
Jan. 27, 1998	DX 1	Dr. Cauhill	Lungs clear; previously identified nodular densities are not present.
Feb. 24, 1998	DX 1	Dr. Tzouanakis	No significant pulmonary abnormalities
Mar. 5, 1998	DX 1	Dr. Cole, BCR, B	Negative for pneumoconiosis; surgical clips, right lung
(same)	DX 1	Dr. Westerfield, B	Negative for pneumoconiosis, profusion category 0/1, ²² type p/q opacities; ²³ right upper lobectomy
(same)	DX 1	Dr. Sargent, BCR, B	Completely negative
Apr. 7, 1998	DX 1	Dr. Cauhill	Linear strand of fibrosis right lung; no acute cardio-pulmonary disease present
May 11, 1998	DX 1	Dr. Tzouanakis	No new pulmonary abnormalities
May 15, 1998	DX 1	Dr. Koriakin	Left lower lobe effusion
Oct. 24, 2001 ²⁴	DX 16	Dr. Patel, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type s opacities; bullous emphysema present
(same)	DX 18	Dr. Wiot, BCR, B	Negative for pneumoconiosis; emphysema present
Jun. 19, 2002	DX 19	Dr. Zaldivar, B	Negative for pneumoconiosis; bullous emphysema present
Sep. 11, 2003	CX 1	Dr. Ahmed, BCR, B ²⁵	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities; emphysema present
(same)	CX 2	Dr. Aycoth, B ²⁶	Positive for pneumoconiosis, profusion category 1/0, type p/q opacities

²²The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2.

²³There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

²⁴Although Dr. Zaldivar expressed his disagreement with Dr. Patel's reading of this film, he did not actually review this chest x-ray. Instead, his opinion was based on his own evaluation of the June 19, 2002 chest x-ray. As a result, I have not listed his opinion as an interpretation of this film.

²⁵I take judicial notice of Dr. Ahmed's board certification and have attached the certification documentation. Additionally, I obtained his qualification as a B reader from the following website: www.oalj.dol.gov/public/blalung/refenc.

²⁶I obtained Dr. Aycoth's qualification as a B reader from the following website: www.oalj.dol.gov/public/blalung/refenc.

Certainly, the radiographic record developed at the time of Mr. Richmond's first claim failed to even suggest the presence of pneumoconiosis. However, coal workers' pneumoconiosis is a latent and progressive disease.²⁷ Consequently, the more relevant chest x-rays are those developed since 2001.

Of the three recent chest x-rays, only the first film caused a medical dispute. Dr. Patel believed the October 24, 2001 chest x-ray was positive for pneumoconiosis. Dr. Wiot disagreed and considered the x-ray negative. Since both physicians are well-qualified experts, their conflicting opinions represent an evidentiary standoff which renders this particular film inconclusive for the presence of pneumoconiosis.

The other two chest x-rays were unequivocal. Dr. Zaldivar's sole reading of the June 19, 2002 film establishes that it is negative for pneumoconiosis. Likewise, the consensus of Dr. Ahmed and Dr. Aycoth demonstrates that the September 11, 2003 chest x-ray is positive for pneumoconiosis. Consequently, the October 2001 chest x-ray is inconclusive, the June 2002 film is negative, and the September 2003 chest x-ray is positive.

Thus, at first consideration, since the earlier films were profoundly negative and no clear preponderance exists among the three most recent films, the radiographic seems to undermine a finding of pneumoconiosis. However, for three reasons, when considering the pattern of the biopsy and radiographic evidence, I conclude the radiographic evidence does not impeach a finding of pneumoconiosis based on Dr. Wilson's biopsy finding of anthracosis.

First, Dr. Zaldivar observed that pneumoconiosis may be found during a biopsy of lung tissue even though the chest x-rays do not show the nodules. His opinion helps resolve the seeming conflict between Dr. Wilson's 1998 positive biopsy finding and the negative films from 1998.

Second, for a related reason, the nebulous state of the chest x-ray findings in 2001, 2002, and 2003, shows a subtle change in the radiographic evidence. Whereas the interpretations in 1997 and 1998 were consistently negative for pneumoconiosis or clear, some radiologists in 2001 and 2003 started to see evidence of pneumoconiosis nodules such that the consensus on the presence of pneumoconiosis in the chest x-rays changed from negative to evenly split.

Third, and most important, as previously mentioned, pneumoconiosis is a progressive disease. I believe the fifteen month passage of time from Dr. Zaldivar's negative finding in June 2002 to the September 2003 positive interpretations by Dr. Ahmed and Dr. Aycoth is sufficient to give the most recent chest x-ray greater probative weight. Consequently, since the most recent film is sufficiently distant from the prior negative interpretation, I find the positive September 11, 2003 represents the preponderance of the more probative radiographic evidence and establishes, consistent with Dr. Wilson's pathology finding, that Mr. Richmond has pneumoconiosis.

²⁷See *Parsons v. Wolf Creek Collieries*, 23 B.L.R. 1-____, BRB No. 02-0188 BLA (Sept. 30, 2004) (en banc) (the potential for progressivity and latency of pneumoconiosis is inherent in every case) and *Workman v Eastern Assoc. Coal Corp.*, BRB No. 02-0727 BLA (Aug. 19, 2004) (order on recon.) (en banc).

*Medical Opinion*²⁸

Under 20 C.F.R. § 718.202 (a) (4), the presence of pneumoconiosis may also be shown through documented and reasoned medical opinion. Prior to summarizing the medical opinion, a review of other pulmonary function tests and the blood gas studies in the record helps place the physicians' assessments into perspective.

Exhibit	Date / Doctor	Age / Height	FEV ¹ pre post	FVC pre post	MVV pre post	% FEV ¹ / FVC pre post	Qualified pre post	Comments
DX 1	Oct. 17, 1997 Dr. Tzouanakis	50 67"	2.66 2.77	3.60 3.62		73% 76%	No ²⁹	
DX 1	Mar. 5, 1998 Dr. Westerfield	50 66"	2.10 2.33	3.62 3.74	54	58% 62%	No ³⁰ No	Invalid due to recent lung surgery

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ₂ (rest) pCO ₂ (exercise)	pO ₂ (rest) pO ₂ (exercise)	Qualified ³¹	Comments
DX 1	Mar. 5, 1998 Dr. Westerfield	38	82	No ³²	
DX 12	Oct. 24, 2001 Dr. Rasmussen	37 38	70 54	No ³³ Yes	Moderate oxygen transfer impairment
DX 19	Jun. 19, 2002 Dr. Zaldivar	29 32	80 75	No ³⁴ No ³⁵	

²⁸Since the physical ailments did not relate to Mr. Richmond's pulmonary condition, I have not included the following treatment notes in the summary: May 1988 – left middle finger injury; March 1997 – chronic back pain stemming from a 1994 motor vehicle accident; April 1998 – post-surgery chest wall incision pain (DX 1).

²⁹The qualifying FEV¹ number is 1.88 for age 50 and 67"; the corresponding qualifying FVC and MVV values are 2.48 and 73, respectively.

³⁰The qualifying FEV¹ number is 1.97 for age 50 and 66"; the corresponding qualifying FVC and MVV values are 2.37 and 75, respectively.

³¹To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO₂ level, the value of the coal miner's pO₂ must be equal to or less than corresponding pO₂ value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

³²For the pCO₂ of 38, the qualifying pO₂ is 62, or less.

³³For the pCO₂ of 37, the qualifying pO₂ is 63, or less.

³⁴For the pCO₂ of 29, the qualifying pO₂ is 71, or less.

³⁵For the pCO₂ of 32, the qualifying pO₂ is 68, or less.

Dr. Ray F. Garman
(DX 1)

On May 15, 1998, Dr. Garman evaluated Mr. Richmond's suitability to return to work. Mr. Richmond had been a coal miner for nineteen years and a mine inspector for another eleven years. His cigarette smoking history covered 32 years, with a daily consumption of half a pack. Mr. Richmond's history included a recent surgery for lung cancer and persistent back pain. He struggled with shortness of breath upon exertion. After a physical examination, which included a finding of tubular breath sounds, Dr. Garman concluded Mr. Richmond had an advanced respiratory impairment caused by lung cancer which precluded his return to employment.

Saint Joseph Hospital Treatment Notes
(DX 1)

In October 1997, after Mr. Richmond presented with chest pain and a chest x-ray and a CT scan identified a 2 by 1.5 centimeter mass in his right upper lung,³⁶ a bronchoscopy was conducted. The test showed that the bronchial trees were normal. The physician obtained a specimen near the lesion; however, a pathologist did not find any significant abnormalities.

Between January 7 and 14, 1998, Mr. Richmond was hospitalized for treatment of lung cancer. During a surgical procedure, a 2 x 3 centimeter mass was identified and a biopsy was positive for squamous carcinoma. Due to the cancer, the right upper lobe of the lung was removed. By January 12, 1998, the chest x-ray was clear.

Dr. B. T. Westerfield
(DX 1)

On March 5, 1998, Dr. Westerfield, board certified in pulmonary disease and internal medicine,³⁷ conducted a pulmonary examination of Mr. Richmond, who had been an underground coal miner for several years. Mr. Richmond had also smoked cigarettes for about 30 years at the rate of a pack a day. He complained about shortness of breath upon exertion.

Upon physical examination, Dr. Westerfield heard normal breath sounds. The chest x-ray was negative for pneumoconiosis. The arterial blood gas study did not disclose an abnormality. The pulmonary function test was invalid due to recent right upper lobectomy. Dr. Westerfield diagnosed lung cancer and COPD (chronic obstructive pulmonary disease) due to cigarette smoking. Mr. Richmond did not have an occupational disease related to his coal mine employment. In the absence of a valid pulmonary function test, Dr. Westerfield did not render a determination on the extent of any pulmonary impairment.

³⁶The CT scan report did not mention the presence of pneumoconiosis. The treating physician, Dr. Tzouanakis, reported that Mr. Richmond had a history of coal dust exposure without evidence of clinical pneumoconiosis (DX 1).

³⁷I take judicial notice of Dr. Westerfield's board certification and have attached the certification documentation.

Dr. D. L. Rasmussen
(DX 11)

On October 24, 2001, Dr. Rasmussen, board certified in internal medicine,³⁸ evaluated Mr. Richmond's pulmonary condition. Mr. Richmond had nearly 20 years of coal mine employment and had performed a variety of tasks, including general insider laborer, supply man, and section foreman. He started smoking cigarettes in 1964 when he was 17 years old and regularly smoked a pack and a half of cigarettes per day. Although he was currently smoking, Mr. Richmond only consumed two cigarettes a day. In 1998, he had a lobectomy for lung cancer. Mr. Richmond reported chronic shortness of breath for several years.

Upon physical examination, Dr. Rasmussen heard moderately diminished breath sounds. The chest x-ray was positive for pneumoconiosis and showed the presence of bullous emphysema. The pulmonary function showed Mr. Richmond had a slightly reversible obstructive ventilatory impairment. According to the arterial blood gas study, he also struggled with an oxygen transfer impairment.

Based on Mr. Richmond's history of coal mine employment and the positive chest x-ray, Dr. Rasmussen diagnosed coal workers' pneumoconiosis. In light of the pulmonary test results, Dr. Rasmussen also determined that Mr. Richmond had COPD/emphysema, which was attributable to both coal dust and cigarette smoke. The same test results also demonstrated that Mr. Richmond had experienced a moderate loss of lung function. As a result, he no longer had the pulmonary capacity to return to coal mining. Because both pulmonary risk factors, cigarette smoke and coal dust, produced similar abnormalities, Dr. Rasmussen believed both factors caused the obstructive impairment, with coal dust being a significant contributing factor. Finally, for two reasons, Dr. Rasmussen concluded Mr. Richmond's right upper lobectomy did not significantly contribute to the impairment. First, although Mr. Richmond suffered the loss of a lung lobe, "his forced vital capacity" had not been reduced below normal. Second, loss of lung function due to the surgery usually does not cause the obstructive-type impairment found in Mr. Richmond's case.

Dr. George L. Zaldivar
(DX 19 and DX 20)

On June 19, 2002, Dr. Zaldivar, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation. At that time, in addition to persistent right leg problems, Mr. Richmond complained about shortness of breath. In January 1998, he had surgery on the right lung for cancer. Having smoked cigarettes since he was seventeen years old at the rate of a pack and a half a day, Mr. Richmond was presently smoking two cigarettes a day. He had been in coal mine-related employment for over 30 years; he spent about 20 years as a coal miner. In his last job, Mr. Richmond was a general laborer and section foreman; his tasks included shoveling and rock dusting.

Upon physical examination, the lungs were clear. Although bullous emphysema was present, the chest x-ray was negative for pneumoconiosis. The arterial blood gas studies did not

³⁸I take judicial notice of Dr. Rasmussen's board certification and have attached the certification documentation.

show total disability. The pulmonary function test indicated the presence of a moderate irreversible obstruction. A carboxyhemoglobin test result indicated Mr. Richmond was a current cigarette smoker.

Based on his examination, Dr. Zaldivar concluded Mr. Richmond did not have coal workers' pneumoconiosis nor "any dust disease of the lungs." Mr. Richmond had a pulmonary impairment due to cigarette smoking and the resection operation on his right lung to remove the cancerous tumor. From a pulmonary perspective, Mr. Richmond was no longer capable of coal mine employment. This disability was attributable to his cigarette smoking habit. Even if Mr. Richmond had coal workers' pneumoconiosis, Dr. Zaldivar would not change his causation determinations because Mr. Richmond has bullous emphysema consistent with cigarette smoking. According to Dr. Zaldivar, "bullous emphysema is never the result of coal workers' pneumoconiosis." Finally, Dr. Zaldivar emphasized that since a lung lobe had been removed in 1998, "[i]t should be a simple matter to secure the samples of tissue from that lung. . .and examine them specifically for the presence or absence of coal workers' pneumoconiosis." The physician added that if some evidence of coal workers' pneumoconiosis were found in the lung tissue, "then some of the obstruction should reasonably be attributable to pneumoconiosis." At the same time, Mr. Richmond's impairment would not be due to such pneumoconiosis. Instead, based on the radiographic evidence of "large bullae," his pulmonary impairment is caused by bullous emphysema, which is unrelated to his coal mine employment.

In March 2003, Dr. Zaldivar reviewed Dr. Rasmussen's pulmonary examination. Dr. Zaldivar noted that Dr. Rasmussen's objective findings were very similar to his test findings. Dr. Zaldivar again emphasized that Mr. Richmond has bullous emphysema due to cigarette smoking, which has destroyed lung tissue and caused holes "where there is no exchange of oxygen." The bullae "represent a large 'hole' within the lungs." Mr. Richmond has several of these "holes," which contribute to his hypoxemia. Dr. Zaldivar continued to disagree with Dr. Patel's finding of pneumoconiosis nodules in the chest x-ray. He observed that an x-ray "may not show nodules which might well be found at tissue biopsy." Regardless of the interpretation, Dr. Zaldivar stressed the chest x-ray evidence was important "to determine how much dust has been inhaled that potentially can cause damage to the lungs." Relatedly, according to a medical study, a coal-dust induced pulmonary obstruction usually does not occur in the absence of evidence of extensive pneumoconiosis, in the form of complicated pneumoconiosis. Thus, when the profusion "category of dust in the lungs is low," as determined by Dr. Patel, "the likelihood of developing airway obstruction is extremely low" because insufficient dust has been inhaled to damage the lungs' airways. Additionally, Dr. Zaldivar stressed that the bullous emphysema in Mr. Richmond's lungs "is a marker of lung destruction produced by smoking and is responsible for the airways obstruction he exhibits."

Discussion

The medical assessments from the late 1990s provide important background information concerning Mr. Richmond's lung cancer and treatment. While the physicians involved in that treatment may have been aware of Dr. Wilson's biopsy report, their focus was on his lung cancer and they did not specifically address the issue of pneumoconiosis. Consequently, their collective silence on pneumoconiosis does not necessarily impeach the biopsy findings. Further, since they

were obviously unaware of the most recent positive chest x-ray interpretations, their treatment notes do not represent contrary medical evidence concerning the presence of clinical pneumoconiosis.

Similarly, Dr. Garman only addressed whether Mr. Richmond could return to work. Based on a physical examination and Mr. Richmond's medical history of lung cancer; the doctor diagnosed his disability in terms of lung cancer. However, his silence on the absence of black lung disease has little contrary probative value because he did not reference the lung biopsy findings and Mr. Richmond's long-term work history as a coal miner.

Mr. Richmond's treating physician, Dr. Tzouanakis, did mention the historical absence of clinical pneumoconiosis. However, the record does not indicate that he was aware of the biopsy finding of anthracosis and his assessment on the significance of the most recent radiographic evidence is not in the record.

When Dr. Westerfield considered whether Mr. Richmond had pneumoconiosis, he found insufficient evidence of black lung disease. Yet, Dr. Westerfield was also unaware of the biopsy finding and the most recent chest x-ray interpretations. Consequently, his negative diagnosis is insufficient to undermine Dr. Wilson's anthracosis diagnosis and the new radiographic interpretations of pneumoconiosis.

Turning to the more recent opinions of Dr. Rasmussen and Dr. Zaldivar, they disagree on whether Mr. Richmond has pneumoconiosis. Based on radiographic evidence, Dr. Rasmussen concluded Mr. Richmond had clinical pneumoconiosis. Additionally, considering coal dust as one of two pulmonary risk factors for Mr. Richmond, Dr. Rasmussen also believed coal dust was a significant contributing factor in the development of Mr. Richmond's obstructive impairment.

In contrast, based on his own chest x-ray interpretation, Dr. Zaldivar concluded Mr. Richmond did not have clinical pneumoconiosis. He also concluded Mr. Richmond's pulmonary condition was due to cigarette smoke and lung cancer, both unrelated to his coal mine employment.

Since neither Dr. Rasmussen nor Dr. Zaldivar considered the lung biopsy report and the chest x-ray interpretations of Dr. Ahmed and Dr. Aycoth, their opinions have little effect on the continuing probative value of the two objective medical findings of pneumoconiosis.

In summary, for various other reasons, I find that the preponderance of the medical opinion does not probatively outweigh Dr. Wilson's biopsy findings from 1998 and the preponderance of the more probative radiographic evidence from 2003, which independently produce the same finding – the presence of pneumoconiosis in Mr. Richmond's lungs. Having accomplished the requisite *Compton* analysis, I conclude that Dr. Wilson's diagnosis of anthracosis and the positive 2003 chest x-ray interpretations by Dr. Ahmed and Dr. Aycoth represent the more probative evidence and establish that Mr. Richmond has pneumoconiosis. Accordingly, Mr. Richmond has proven the first requisite element of entitlement.

Pneumoconiosis Arising Out of Coal Mine Employment

Once a claimant has proven the existence of pneumoconiosis, 20 C.F.R. § 718.203 (a) requires that he also establish that his pneumoconiosis arose at least in part from his coal mine employment. According to 20 C.F.R. § 718.203 (b), if the claimant was employed in coal mining for ten or more years, a rebuttable presumption that the pneumoconiosis is due to coal mine employment exists.

As I previously determined, Mr. Richmond has at least 15 and a half years of coal mine employment. Consequently, he is entitled to the presumption that his pneumoconiosis is related to his coal mine employment. Although Mr. Richmond was employed as a coal mine inspector for eleven years after he left his work as a coal miner, his occupational dust exposure as an inspector was neither as intensive nor extensive as his work as a coal miner. As a result, I conclude insufficient evidence exists in the record to rebut the presumption that Mr. Richmond's clinical pneumoconiosis is due to his coal mine employment. Through the un-rebutted presumption, Mr. Richmond has proven that he has coal worker's pneumoconiosis.

Total Disability

As previously mentioned in considering whether Mr. Richmond had established a material change in condition, to receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. By establishing the requisite material change in condition through the preponderance of the most recent pulmonary function tests, as additionally supported by the consensus of Dr. Rasmussen and Dr. Zaldivar on the issue of total disability, Mr. Richmond has proven the third element of entitlement. He has a totally disabling respiratory impairment.

Total Disability Due to Coal Workers' Pneumoconiosis

Because Mr. Richmond has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Under 20 C.F.R. § 718.204 (c) (1), absent regulatory presumptions in favor of a claimant,³⁹ the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204 (c) (2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

³⁹20 C.F.R. § 718.305 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption the claimant is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more of coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and, 20 C.F.R. § 718.306 (a presumption exists when a survivor files a claim prior to June 30, 1982).

And so I return to the medical opinion in the record and consider the causation assessments of the three physicians who believed Mr. Richmond was totally disabled.

Dr. Garman attributed Mr. Richmond's pulmonary impairment to lung cancer. Yet, due to the limited documentary foundation of his opinion (medical history and physical examination), his opinion has diminished probative value.

Dr. Rasmussen identified three pulmonary issues in Mr. Richmond's case, lung cancer, coal dust exposure, and long-term cigarette smoking. Based on the characteristics of the pulmonary function tests, Dr. Rasmussen believed the lobectomy had little effect on pulmonary impairment. Specifically, the physician highlighted Mr. Richmond's near-normal forced vital capacity and opined the obstructive impairment established by the pulmonary function tests was not a typical symptom for the loss of a lung lobe. On the other hand, since both coal dust and cigarette smoke cause similar abnormalities, Dr. Rasmussen concluded both of these pulmonary risk factors caused Mr. Richmond's pulmonary impairment. In other words, coal dust was a significant contributing factor in his inability to return to coal mine employment.

Dr. Zaldivar believed both lung cancer and cigarette smoking were responsible for Mr. Richmond's impairment; with the later pulmonary risk the greater causation factor. Dr. Zaldivar explained that Mr. Richmond had bullous emphysema which a) caused his impairment; b) is associated with cigarette smoking; and, c) not caused by coal dust. According to the physician, the bullous emphysema produced holes in Mr. Richmond's lung tissue which caused his obstructive impairment and oxygen transfer problems. Although Mr. Richmond had neither clinical nor legal pneumoconiosis, Dr. Zaldivar expressed his opinion that if radiographic evidence of pneumoconiosis were present or the lung biopsy contained pneumoconiosis, its presence would be minimal in comparison with the cigarette smoke-induced bullous emphysema. As a result, while the pneumoconiosis would have caused some of the obstruction, its contribution to the pulmonary impairment would not be significant. To further support his conclusion, Dr. Zaldivar also noted that pneumoconiosis usually causes a significant pulmonary obstruction only when its presence is extensive. The low profusion demonstrated by chest x-ray interpretations that are barely sufficient to establish pneumoconiosis would not cause an obstructive impairment.

The probative value assessment of the divergent opinions of Dr. Rasmussen and Dr. Zaldivar involves numerous, and sometimes conflicting, considerations. First, in terms of professional qualifications, as a board certified pulmonary specialist, Dr. Zaldivar possesses the greater demonstrated medical expertise in the area of pulmonary disease and the lungs.

Second, on the other hand, although Dr. Rasmussen was unaware of Dr. Wilson's biopsy findings and the two most recent positive chest x-ray interpretations, his finding of clinical pneumoconiosis is consistent with my determination that preponderance of the more probative medical evidence establishes the presence of clinical pneumoconiosis in Mr. Richmond's lung. In contrast, Dr. Zaldivar did not diagnose pneumoconiosis and considered its potential for causing an impairment only in hypothetical terms.

Third, highlighting the near-normal forced vital capacity and inconsistency of an obstruction impairment with a lobectomy, Dr. Rasmussen provided a better reasoned opinion than Dr. Zaldivar on why Mr. Richmond's lung cancer and resulting lobectomy were not significant factors in the obstructive impairment.

Fourth, however, Dr. Rasmussen's terse analysis finding Mr. Richmond's coal dust exposure as a significantly contributing causation factor in his pulmonary obstruction diminishes the probative value of his assessment. Essentially, Dr. Rasmussen relies on two basic conclusions: a) Mr. Richmond had been exposed to two pulmonary risk factors, coal dust and cigarette smoke; and b) coal dust and cigarette smoke cause similar abnormalities. While in one jurisdiction, Dr. Rasmussen's causation conclusion may be sufficiently probative to establish causation,⁴⁰ I find he failed to explain in Mr. Richmond's case how he concluded pneumoconiosis was a significant factor within the lungs filled with extensive bullous emphysema.⁴¹

Fifth, in comparison, Dr. Zaldivar provided a more specific and better reasoned explanation about the cause of Mr. Richmond's obstructive pulmonary defect based on the characteristics of the emphysema in his lungs. Even if coal workers' pneumoconiosis were established by a lung biopsy,⁴² Dr. Zaldivar emphasized that Mr. Richmond's principle pulmonary defect was bullous emphysema, which is directly linked to cigarette smoke. The large areas of lung damage caused by this particular type of cigarette smoke-induced emphysema was responsible for the significant obstructive impairment established by the pulmonary function tests.

Sixth, yet to further support his conclusion that pneumoconiosis had little effect on Mr. Richmond's lungs, Dr. Zaldivar diminished the probative value of his analysis by venturing into the murky boundary between the medical and legal definitions of pneumoconiosis. Having provided a more probative explanation about the cause of Mr. Richmond's pulmonary obstructive defects in terms of bullous emphysema, Dr. Zaldivar then referenced a medical study indicating that an obstruction due to coal dust occurs only when the underlying pneumoconiosis is extensive and severe. While that conclusion may be medically sound, it effectively states that only severe clinical pneumoconiosis can cause an obstructive impairment. However, in establishing a legal definition of pneumoconiosis, the Benefits Review Board and courts have recognized that pneumoconiosis may cause an obstructive impairment. Unlike medical science, due to the statutory and regulatory definitions of pneumoconiosis, these judicial determinations do not require the presence of severe clinical pneumoconiosis as a prerequisite for finding an obstructive impairment caused by coal dust exposure. In other words, Dr. Zaldivar's referenced medical study is inconsistent with the statutory, regulatory and judicial standard that legal pneumoconiosis, standing alone, may cause an obstructive impairment. Unlike some physicians,

⁴⁰See *Cornett v. Benham Coal Co., Inc.* 227 F.3d 569 (6th Cir. 2000).

⁴¹Without explanation, Dr. Rasmussen also concluded Mr. Richmond's emphysema was caused in part by his coal dust exposure. Again, considering the nature of the emphysema highlighted by Dr. Zaldivar, Dr. Rasmussen's simple conclusion about the presence of legal pneumoconiosis has little probative value.

⁴²Dr. Zaldivar was also unaware of Dr. Wilson's positive biopsy findings.

the legal community imposes no requirement that the extent of the clinical pneumoconiosis be severe, or complicated, prior to a determination that it caused a pulmonary obstruction.

In summary, while Dr. Rasmussen provided the better reasoned opinion on eliminating lung cancer as a factor in Mr. Richmond's total disability, his insufficiently explained analysis about the respective causation effects of coal dust and cigarette smoke, renders his opinion probatively deficient. In comparison, on the relationship between Mr. Richmond's bullous emphysema and his exposures to coal dust and cigarette smoke, Dr. Zaldivar provided a better reasoned and more probative opinion. At the same time, Dr. Zaldivar's dismissal of pneumoconiosis, if present, as a significant causation factor has diminished probative value due to his medically-narrowed view of legal pneumoconiosis. Due to these mixed probative value findings, neither Dr. Rasmussen nor Dr. Zaldivar definitively establish whether Mr. Richmond's coal workers' pneumoconiosis was a significant contributing cause of his total pulmonary impairment. Accordingly, since he carries the burden of proof on this issue, Mr. Richmond is unable to establish by the preponderance of the more probative medical opinion that he is totally disabled due to pneumoconiosis.

CONCLUSION

Through the most recent pulmonary function tests, Mr. Richmond has established that he is totally disabled due to a pulmonary impairment, which represents a change in his physical condition that warrants reconsideration of the entire record. Based on that review, I conclude that Mr. Richmond also has pneumoconiosis due to his coal mine employment. However, principally due to the diminished probative value of Dr. Rasmussen's medical opinion, Mr. Richmond is unable to prove the fourth requisite element of entitlement – total disability due to coal workers' pneumoconiosis. Accordingly his claim for disability benefits under the Act must be denied.

ORDER

The claim of Mr. DAVID D. RICHMOND for benefits under the Act is **DENIED**.

SO ORDERED:

A
RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: November 16, 2004
Washington, DC

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481 (2001), any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. § 725.478 (2001) and § 725.479 (2001). A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

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Attachment No. 4

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